

DEPARTMENT OF HEALTH AND HUMAN SERVICES  
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 06/09/2011

FORM APPROVED

OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  155697		X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING		X3) DATE SURVEY COMPLETED 05/13/2011	
NAME OF PROVIDER OR SUPPLIER  CLARK REHABILITATION AND SKILLED NURSING CENTER				STREET ADDRESS, CITY, STATE, ZIP CODE 517 N LITTLE LEAGUE BLVD CLARKSVILLE, IN47129			
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F0000	<p>This visit was for Investigation of Complaints IN00090093 and IN00090287.</p> <p>Complaint IN00090093 - Substantiated. Federal/state deficiencies related to the allegations are cited at F157, F282, F309, and F333.</p> <p>Complaint IN00090287 - Substantiated. Federal/state deficiencies related to the allegations are cited at F282, F309, F333, and F441.</p> <p>Unrelated deficiencies are cited.</p> <p>Survey date: 5/11, 5/12, and 5/13/11</p> <p>Facility number: 000059 Provider number: 155697 AIM number: 100266560</p> <p>Survey team: Jennie Bartelt, RN</p>			F0000			

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE

(X6) DATE

Any deficiency statement ending with an asterisk (\*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (see instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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	Census bed type: SNF: 10 SNF/NF: 61 Total: 71  Census payor type: Medicare: 14 Medicaid: 48 Other: 9 Total: 71  Sample: 9  These deficiencies also reflect state findings cited in accordance with 410 IAC 16.2.  Quality review completed 5-16-11 Cathy Emswiller RN						

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F0157 SS=D	<p>A facility must immediately inform the resident; consult with the resident's physician; and if known, notify the resident's legal representative or an interested family member when there is an accident involving the resident which results in injury and has the potential for requiring physician intervention; a significant change in the resident's physical, mental, or psychosocial status (i.e., a deterioration in health, mental, or psychosocial status in either life threatening conditions or clinical complications); a need to alter treatment significantly (i.e., a need to discontinue an existing form of treatment due to adverse consequences, or to commence a new form of treatment); or a decision to transfer or discharge the resident from the facility as specified in §483.12(a).</p> <p>The facility must also promptly notify the resident and, if known, the resident's legal representative or interested family member when there is a change in room or roommate assignment as specified in §483.15(e)(2); or a change in resident rights under Federal or State law or regulations as specified in paragraph (b)(1) of this section.</p> <p>The facility must record and periodically update the address and phone number of the resident's legal representative or interested family member.</p> <p>Based on record review and interview, the facility failed to ensure follow-up with the physician related to treatment plans for a resident whose lab work indicated bacteria in the urine (Resident B). The deficient practice affected 1 of</p>			F0157	<p>The creation and submission of this plan of correction does not constitute an admission by this provider of any conclusion set forth in the statement of deficiencies, or of any violation of regulation.</p> <p>This provider respectfully requests that the 2567 plan of correction be considered the</p>		05/27/2011

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	<p>8 residents reviewed related to physician notification in a sample of 9.</p> <p>Findings include:</p> <p>The clinical record for Resident B was reviewed on 5/11/11 at 12:45 p.m. The record indicated the resident's diagnoses included, but were not limited to, urinary retention, and the resident had a Foley urinary catheter.</p> <p>A physician's order, dated 3/6/11, indicated the resident was started on an antibiotic for 10 days related to urinary tract infection. The order also indicated, "Reculture urine 24 hours after last dose."</p> <p>A lab report indicated urine was collected 3/17/11 and urinalysis results were received that same date with the following indicated, "Culture, urine Microbiology test to follow on separate report." An unsigned, undated handwritten notation on the report indicated,</p>				<p>letter of credible allegation and requests a Desk review on or after 5/27/2011</p> <p><b>F 157 Notify of changes (Injury/Decline/ Room, Etc.) identifying all laboratory orders. DNS/designee will monitor audits, to ensure completion of audits.</b></p> <p>Data collected will be submitted to the CQI Committee for review and follow up as needed. An action plan will be developed as needed for issues identified by the CQI process. It is the practice of this provider to ensure that the attending physician is notified of a need for follow-up of lab work.</p> <p><b>What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice:</b></p> <p><b>How will you identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken:</b></p> <p><b>What measures will be put into place or what systemic changes you will make to ensure that the deficient practice does not recur</b></p> <p>Licensed nurses were educated on 5/26/2011 on the policy for laboratory orders, including notifying physician and post tests completed</p> <p>Treatment Administration Records were reviewed to ensure all lab orders present.</p> <p>The DNS/designee will log and</p>		

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	<p>"MD aware."</p> <p>A lab report for Culture and Sensitivity, dated 3/19/11 indicated, "Organisms: 1) Pseudomonas aeruginosa &gt; [greater than] 100,000 CFU/ml [colony forming units/per milliliter]...."</p> <p>A lab report for Culture and Sensitivity, dated, 3/21/11 indicated, "1)Pseudomonas aeruginosa &gt;100,000 CFU/ml 2) Enterococcus faecalis 50-60,000 CFU/ml 3)Yeast present, no sens [sensitivity] will be done 50-60,000. Handwritten information, undated, unsigned, and lined through on this report beneath a list of antibiotics to which the organisms were susceptible was: "Cefdinir [antibiotic] 300 mg Line place 1 gm IV [intravenous] q [every 12 hours] X 7 days." Initials on page one of the report were dated 4/5/11, and initials on page two of the report were dated 4/1/11.</p>				<p><b>track lab orders on Lab Tracking Log to include date of order, date lab notified, date drawn, date results received and date physician notified. How the corrective action(s) will be monitored to ensure the deficient practice will not recur A CQI Audit of laboratory tool will be utilized weekly x 4 monthly x 2 then quarterly thereafter to monitor for compliance.</b></p> <p>Compliance Date: 5/27/2011</p> <p>::</p> <p>The facility recognizes that residents with laboratory orders have the potential to be affected by this practice. A full facility audit was conducted All medical records identified were reviewed to ensure physician notification was completed. Licensed nurses were educated on 5/26/2011 on the policy for laboratory orders including notifying physician with post test completed.. The physician was notified of the lab results of resident B on 4/5/11 for medication clarification and again on 4/6/11 with stat lab ordered. Lab was completed showing potassium level within normal limits.</p>		

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	<p>Nurse's Notes, dated 3/20/11 at 2:00 a.m., indicated, "Lab report received, NP [nurse practitioner] [name] notified, instructions received to fax labs to office...."</p> <p>Documentation failed to indicate further contact with the physician or nurse practitioner for follow-up treatment for the resident related to the abnormal lab reports.</p> <p>During interview on 5/12/11 at 4:45 p.m., and again at 5:15 p.m. the facility's Nurse Consultant on 5/12/11 indicated she did not yet have an answer to the question related to the follow-up with the physician related to the abnormal labs and was still looking for information. She also indicated the initials on 4/1/11 and 4/5/11 indicated the Nurse Practitioner had seen the report dated 3/21/11, several days after the report was faxed to the physician's office for follow-up. No further information was provided.</p>						

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	This federal tag relates to Complaint #IN00090093.  3.1-5(a)(3)						

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F0225 SS=D	<p>The facility must not employ individuals who have been found guilty of abusing, neglecting, or mistreating residents by a court of law; or have had a finding entered into the State nurse aide registry concerning abuse, neglect, mistreatment of residents or misappropriation of their property; and report any knowledge it has of actions by a court of law against an employee, which would indicate unfitness for service as a nurse aide or other facility staff to the State nurse aide registry or licensing authorities.</p> <p>The facility must ensure that all alleged violations involving mistreatment, neglect, or abuse, including injuries of unknown source and misappropriation of resident property are reported immediately to the administrator of the facility and to other officials in accordance with State law through established procedures (including to the State survey and certification agency).</p> <p>The facility must have evidence that all alleged violations are thoroughly investigated, and must prevent further potential abuse while the investigation is in progress.</p> <p>The results of all investigations must be reported to the administrator or his designated representative and to other officials in accordance with State law (including to the State survey and certification agency) within 5 working days of the incident, and if the alleged violation is verified appropriate corrective action must be taken.</p> <p>Based on record review and interview, the facility failed to ensure an allegation of abuse was investigated for 1 of 1 resident</p>			F0225	<p><b>This provider respectfully requests additional evidentiary information be entered into the 2567L and removal of citation for resident J. The current 2567L information omits</b></p>		05/27/2011

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	<p>reviewed related to allegations of abuse in a sample of 9. (Resident J)</p> <p>Findings include:</p> <p>During interview on 5/12/11 at 1:35 p.m., Resident J indicated about a month ago he was assaulted by LPN #3. Resident J indicated the nurse came into his room and said she needed to take his vital signs, and "I said no - she proceeded anyway, and the struggle took place." When asked if he pushed her away, the resident indicated he had when she tried to grab his arm, so she tried to put the blood pressure cuff on his leg, and he kicked at her. The resident indicated he had a stroke in the past and did not have use of his left arm and left leg. He indicated the nurse said she would put the blood pressure cuff on his left leg. He indicated he could not straighten his left leg completely since his stroke. The resident indicated the nurse took her fist and hit his left knee cap hard to make his leg go</p>				<p><b>significant facility information and therefore misrepresents the care and assessment administered by the provider. Resident J is diagnosed with personality disorder and care planned for chronic complaints about staff, peers and care; verbal and physical aggression toward staff and peers; and making false statements and accusations toward staff. Per surveyor comment on page 6 of 43 " the facility failed to ensure an allegation of abuse was investigated for 1 or 1 residents reviewed related to allegations of abuse in a sample of 9"</b>This implies that the facility had an allegation that the resident claimed related to abuse and that no investigation was completed. Resident J did have an episode of refusal of care on 4-5-11. The resident concern for behavior grew when resident became physically aggressive with nurse for no apparent reason. Further investigation was completed by Executive Director, due to resident J had wanted to exercise his right to refuse all his medications and care and he wanted the nurse discharged from the facility. Executive Director wanted to reassure him of his rights but also provide further understanding that there are</p>		

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	<p>out straight. The resident indicated he had talked to the Administrator and Director of Nursing about the situation.</p> <p>During the same interview, Resident J indicated on the day before the incident about the vital signs, he was making his way slowly in his wheel chair down the 20-hall near the nurse's station. He indicated with one arm and leg functioning, he could not move very fast. The resident indicated the EMTs (Emergency Medical Technicians) were coming down the hall with a resident on a gurney, and he was trying to get out of their way. He indicated the situation was not an emergency run, and he was moving as quickly as he could. The resident indicated LPN #3 hollered at him from behind the nurse's station to get out of the way, jumped up from behind the counter, and came and shoved his wheel chair hard to get him out of the way. Resident J did not indicate he had reported this incident.</p>				<p>risks to his own health and wellness by refusals of care and furthermore, nursing must also provide that education. The facility contends that an investigation was completed to ensure that there was no allegation of abuse. Although no allegation from resident was made, the nurse was educated on abuse policy for the prevention of potential of abuse. Nurse was explained that per resident request, nurse would not be assigned to resident. It is the practice of this facility to ensure an allegation of abuse is investigated. The policy was followed as evidenced based by which a concern was brought to the attention of the ED when resident J made an allegation of abuse on 4/25/11 to ISDH surveyor that resident's right to refuse was violated on 4/5/11. Once the allegation was made the ED immediately responded and an investigation was initiated. The nurse was suspended upon further investigation. Resident and former roommate, as well as staff was interviewed. Staff member and former roommate had no care concerns from nurse. During investigation, resident spoke to ISDH surveyor and stated nurse had forced him to take vitals and</p>		

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	<p>On 5/12/11 at 4:45 p.m. during interview about the Resident J's report of assault, the Administrator provided copy of a Fax Incident Reporting Form, dated 4/25/11, from a file folder and the facility's Abuse Prohibition, Reporting, and Investigation Policy and Procedure. The Administrator indicated she could allow only the Fax Incident Reporting Form to be reviewed, since the remainder of the file related to the incident was confidential.</p> <p>Review of the Fax Incident Reporting Form indicated the resident involved was Resident J, and the staff was LPN #3. The "Brief Description of Incident" indicated, "On 4/25/11 Resident allegation to ISDH [Indiana State Department of Health] surveyor that resident's right to refuse was violated on 4/5/11. Allegation was Nurse held resident and forced to take VS [vital signs] when resident declined. Resident has a history of</p>				<p><b>assaulted him by violating his right to refuse. Resident met with Ombudsman and claimed that the nurse took his blood pressure on the right side. Then stated to ED that she took her right hand and slammed his arm on the bed and tried to put cuff on arm then resident tried to pin her hand down. Then claimed that she took her fist and pinned his leg down and tried to take Bp on left leg. His story became more and more elaborate as he developed the allegation when interviewed each time with each interviewer. Resident has a way of word manipulation to his best interest. Resident is care planned for tendency for provoking peers by using obscene gestures and calling names. Resident is diagnosed with personality disorder and is being treated and followed by psychiatrist. The facility contends that an investigation was completed and the procedures for abuse policy was followed for resident J and respectfully requests the removal of the citation. The facility did in fact investigate, suspend employee, and report when a true concern was identified. However, in response to the alleged deficient practice the following corrective action has been</b></p>		

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	<p>false accusations and is care planned. Resident did not report above allegation to facility until 4/6/11."</p> <p>During the Exit Conference on 5/12/11 at 5:45 p.m., the Administrator indicated she would allow review of the file of the incident with Resident J but could allow no copies of certain confidential documentation to be made.</p> <p>A file folder labeled with the name of Resident J and the date of 4/5/11 was provided by the Administrator for review on 5/13/11 at 12:45 p.m. The folder included, but was not limited to, documentation on a form titled, "Resident Event Investigation Questionnaire." The Questionnaire indicated a date of 4/7/11 related to an incident on 4/5/11. The form indicated, "Nature of Event: Res. Abuse: Allegation ?" The folder also included a statement written and signed by LPN #3 indicating the</p>				<p><b>implemented. <input type="checkbox"/> Nurse was suspended pending further investigation. Multiple employees and residents were questioned and no trends of concerns for care were found. ED will continue to use facility form for investigation to include larger sample of questionnaire of staff and residents. Ombudsman contacted for support to resident. Counseling and 1:1 visits offered to resident as suggested by Ombudsman; however, resident continues to deny these services. This information was reviewed by the surveyors during annual survey and no deficiencies were cited.</b></p> <p><b>F225 - Addendum</b> How other residents having the potential to be affected by the same deficient practice will be identified and what corrective action(s) will be taken?</p> <ul style="list-style-type: none"> <li>· Due to the nature of the citation, all residents have the potential to be effected by the same alleged deficient practice.</li> <li>· Nurse was suspended pending further investigation.</li> <li>· Multiple employees and</li> </ul>		

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	<p>following: on the morning of 4/5/11, LPN #3 attempted three times to administer the resident's medications, and the resident refused; medical records informed the nurse the resident's physician was enroute to the facility and needed the resident's vital signs taken before he arrived; the nurse put her left hand on the resident's bed rail to get the blood pressure, and the resident began yelling and cursing; the resident scratched the nurse's left hand with his right hand; the nurse tried to leave the room, the resident hit and kicked at the nurse multiple times; and the nurse only attempted to obtain vital signs on the resident's right arm. The folder also included documentation of inservice provided to LPN #3 on 4/7/11 related to "Abuse Prevention, Resident Rights, Approach [symbol for with] Resident, Ensure to approach calmly, provide personal space, attempt with different staff member. Reviewed behavior care plan."</p>				<p>residents were interviewed and no trends of concerns for care were found.</p> <p>What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur?</p> <ul style="list-style-type: none"> <li>ED will continue to use facility form for investigation to include larger sample of questionnaire of staff and residents.</li> <li>CQI Audit tool will be utilized for each investigation to ensure compliance with investigation and reporting procedures.</li> </ul> <p>How the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e what quality assurance program will be put into place?</p> <ul style="list-style-type: none"> <li>ED/Designee will audit using CQI Tool monthly for each investigation to ensure compliance with investigation and reporting procedures.</li> </ul> <p>By what date the systemic changes will be completed?</p> <p>June 6, 2011</p>		

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	<p>During interview with the Administrator on 5/13/11 at 2:45 p.m., the Administrator indicated the incident on 4/5/11 was not investigated as an allegation of abuse and reported to the Indiana State Department of Health, because the resident was not alleging assault. The Administrator indicated the concern about the nurse had come up during a conversation between her and the resident, and when she had asked the resident if the nurse had put her hands on him, he said no. The Administrator indicated the resident is manipulative and now is using the idea about the nurse putting her hands on him, since he wants the nurse fired. The Administrator indicated she did not interview anyone except the resident's former roommate about the incident on 4/5/11, and she did not write documentation related to the interview. The Administrator indicated the resident's behaviors and management of the resident's</p>						

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	<p>behaviors are discussed frequently at Interdisciplinary Team meetings. The Administrator indicated the resident reported the incident as assault to the state surveyors on 4/25/11 during the facility's recent recertification survey.</p> <p>During the same interview, he Administrator indicated the allegation of abuse was reported to the Indiana State Department of Health when state surveyors reported the resident's allegation of assault to her on 4/25/11. The Administrator indicated her notes about the allegation of assault from the surveyors were the "chicken scratch" documentation in the file. The Administrator looked at the documentation and indicated the surveyors told her: the resident reported assault; the nurse took her right hand and slammed on the bed; the nurse took her fist, pinned his leg down, and tried to take his blood pressure on his left leg; and the nurse put her hands on him without permission, and gave no</p>						

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	<p>explanation of why she had to get the blood pressure. The Administrator indicated she may have made notes in the resident's record related to the allegation of assault reported by the surveyors.</p> <p>An Employee Communication Form in the file folder indicated LPN #3 was suspended 4/25/11 and returned to work 4/25/11. The form indicated, "Employer Statement: On 4/25/11 it was alleged that EE [meaning uncertain] assaulted resident per resident's claim," and "Summary of Discussion with Employee: Per Abuse Prohibition, Reporting &amp; Investigation, it is the facility policy to remove staff and remain suspended until investigation is completed. Upon investigation, resident story changed and EE story remain the same. No abuse was found. EE may return after reading resident rights and completion of test."</p> <p>During the same interview, the Administrator indicated no further</p>						

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	<p>investigation into the allegation was made after surveyors reported to her that the nurse had assaulted the resident.</p> <p>Resident J's record was reviewed on 5/13/11 at 3:15 p.m. The record indicated the resident's diagnoses included, but were not limited to, vascular uncomplicated dementia, joint contracture, mood disorder, and hemiplegia.</p> <p>Interdisciplinary Progress Notes, dated 4/26/11 at 5:00 p.m. and signed by the Administrator, indicated, "This writer spoke with Ombudsman [name of local Ombudsman] r/t [related to] meeting with resident. Resident alleged that nurse forced him to get vitals X 2 once in his right arm and then on his right leg/ankle which was different from his allegation from previous interviews. Resident has a history of making false accusations toward staff...." The documentation failed to indicate further investigation into the</p>						

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F0226 SS=D	<p>allegation of assault reported by the state surveyors on 4/25/11.</p> <p>3.1-28(d)</p> <p>The facility must develop and implement written policies and procedures that prohibit mistreatment, neglect, and abuse of residents and misappropriation of resident property. Based on record review and interview, the facility failed to ensure its policy was followed related to investigation of allegations of abuse for 1 of 1 resident reviewed related to allegations of abuse in a sample of 9. (Resident J)</p> <p>Findings include:</p> <p>The facility's policy and procedure for Abuse Prohibition, Reporting, and Investigation was provided by the Administrator on 5/12/11 at 4:45 p.m. In the section of the policy titled "Resident Abuse - Staff member, volunteer, or visitor" indicated, "...9. Residents will be questioned (if alert and competent) about the nature of the incident, and</p>		F0226	<p>This provider respectfully requests additional evidentiary information be entered into the 2567L and removal of citation for resident J. The current 2567L information omits significant facility information and therefore misrepresents the care and assessment administered by the provider. Executive Director reported to ISDH once facility became aware of the allegation. The information obtained prior to the surveyor did not meet the reportable guidelines. Reportable policy was followed, once the allegation of abuse was brought to the facility's attention. Resident J is diagnosed with personality disorder and care planned for chronic complaints about staff, peers and care; verbal and physical aggression toward staff and peers; and making false statements and accusations toward staff. Per surveyor comment on page 6 of 43 " the facility failed to ensure an allegation of abuse was investigated for 1 or 1 residents reviewed related to allegations of</p>		05/27/2011	

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	<p>their statement will be put in writing. 10. An investigation will be done to assure other residents have not been affected by the incident or inappropriate behavior, and the results documented. 11. The investigation will include: Facts and observations by involved employees; Facts and observations by witnessing employee; Facts and observations by witnessing non-employees; Facts and observations from others who might have pertinent information; Facts and observations by the supervisor or individual when the initial report was made...."</p> <p>During interview on 5/12/11 at 1:35 p.m., Resident J indicated about a month ago he was assaulted by LPN #3. Resident J indicated the nurse came into his room and said she needed to take his vital signs, and "I said no - she proceeded anyway, and the struggle took place." When asked if he pushed her away, the resident indicated he had when she tried to grab his arm,</p>				<p>abuse in a sample of 9" This implies that the facility had an allegation that the resident claimed related to abuse and that no investigation was completed. Resident J did have an episode of refusal of care on 4-5-11. The resident concern for behavior grew when resident became physically aggressive with nurse for no apparent reason. Further investigation was completed by Executive Director, due to resident J had wanted to exercise his right to refuse all his medications and care and he wanted the nurse discharged from the facility. Executive Director wanted to reassure him of his rights but also provide further understanding that there are risks to his own health and wellness by refusals of care and furthermore, nursing must also provide that education. The facility contends that an investigation was completed to ensure that there was no allegation of abuse. Although no allegation from resident was made, the nurse was educated on abuse policy for the prevention of potential of abuse. Nurse was explained that per resident request, nurse would not be assigned to resident. It is the practice of this facility to ensure an allegation of abuse is investigated. The policy was followed as evidenced based by which a concern was brought to the attention of the ED when</p>		

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	<p>so she tried to put the blood pressure cuff on his leg, and he kicked at her. The resident indicated he had a stroke in the past and did not have use of his left arm and left leg. He indicated the nurse said she would put the blood pressure cuff on his left leg. He indicated he could not straighten his left leg completely since his stroke. The resident indicated the nurse took her fist and hit his left knee cap hard to make his leg go out straight. The resident indicated he had talked to the Administrator and Director of Nursing about the situation.</p> <p>The resident also indicated on the day before this incident, he was making his way slowly in his wheel chair down the 20-hall near the nurse's station. He indicated with one arm and leg functioning, he could not move very fast. The resident indicated the EMTs (Emergency Medical Technicians) were coming down the hall with a resident on a gurney, and he was</p>				<p>resident J made an allegation of abuse on 4/25/11 to ISDH surveyor that resident's right to refuse was violated on 4/5/11. Once the allegation was made the ED immediately responded and an investigation was initiated. The nurse was suspended upon further investigation. Resident and former roommate, as well as staff was interviewed. Staff member and former roommate had no care concerns from nurse. During investigation, resident spoke to ISDH surveyor and stated nurse had forced him to take vitals and assaulted him by violating his right to refuse. Resident met with Ombudsman and claimed that the nurse took his blood pressure on the right side. Then stated to ED that she took her right hand and slammed his arm on the bed and tried to put cuff on arm then resident tried to pin her hand down. Then claimed that she took her fist and pinned his leg down and tried to take Bp on left leg. His story became more and more elaborate as he developed the allegation when interviewed each time with each interviewer. Resident has a way of word manipulation to his best interest. Resident is care planned for tendency for provoking peers by using obscene gestures and calling names. Resident is diagnosed with personality disorder and is being treated and followed by psychiatrist. The</p>		

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	<p>trying to get out of their way. He indicated the situation was not an emergency, and he was moving as quickly as he could. The resident indicated LPN #3 hollered at him from behind the nurse's station to get out of the way, jumped up from behind the counter, and came and shoved his wheel chair hard to get him out of the way. Resident J did not indicate he had reported this incident.</p> <p>On 5/12/11 at 4:45 p.m., during interview related to the assault, the Administrator provided copy of a Fax Incident Reporting Form, dated 4/25/11, from a file folder and the facility's Abuse Prohibition, Reporting, and Investigation Policy and Procedure. During interview at this time, the Administrator indicated she could allow only the Fax Incident Reporting Form to be reviewed, since the remainder of the file related to the incident was confidential.</p> <p>Review of the Fax Incident</p>				<p>facility contends that an investigation was completed and the procedures for abuse policy was followed for resident J and respectfully requests the removal of the citation. The facility did in fact investigate, suspend employee, and report when a true concern was identified. However, in response to the alleged deficient practice the following corrective action has been implemented. <input type="checkbox"/> Nurse was suspended pending further investigation.</p> <p>Multiple employees and residents were questioned and no trends of concerns for care were found. ED will continue to use facility form for investigation to include larger sample of questionnaire of staff and residents. Ombudsman contacted for support to resident. Counseling and 1:1 visits offered to resident as suggested by Ombudsman; however, resident continues to deny these services. This information was reviewed by the surveyors during annual survey and no deficiencies were cited.</p> <p><b>F226 - Addendum</b> <b>How other residents having the potential to be affected by the same deficient practice will be identified and what corrective action(s) will be taken?</b></p> <p>Due to the nature of the</p>		

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	<p>Reporting Form indicated the resident involved was Resident J, and the staff was LPN #3. The "Brief Description of Incident" indicated, "On 4/25/11 Resident allegation to ISDH [Indiana State Department of Health] surveyor that resident's right to refuse was violated on 4/5/11. Allegation was Nurse held resident and forced to take VS [vital signs] when resident declined. Resident has a history of false accusations and is care planned. Resident did not report above allegation to facility until 4/6/11."</p> <p>During the Exit Conference on 5/12/11 at 5:45 p.m., the Administrator indicated she would allow review of the file of the incident with Resident J but could allow no copies of certain confidential documentation to be made.</p> <p>A file folder labeled with the name of Resident J and the date of 4/5/11 was provided for review on 5/13/11</p>				<p>citation, all residents have the potential to be effected by the same alleged deficient practice.</p> <ul style="list-style-type: none"> <li>Nurse was suspended pending further investigation.</li> <li>Multiple employees and residents were interviewed and no trends of concerns for care were found.</li> </ul> <p><b>What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur?</b></p> <ul style="list-style-type: none"> <li>ED will continue to use facility form for investigation to include larger sample of questionnaire of staff and residents.</li> <li>CQI Audit tool will be utilized for each investigation to ensure compliance with investigation and reporting procedures.</li> </ul> <p><b>How the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e what quality assurance program will be put into place?</b></p> <ul style="list-style-type: none"> <li>ED/Designee will audit using CQI Tool monthly for</li> </ul>		

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	<p>at 12:45 p.m. The folder included, but was not limited to, documentation on a form titled, "Resident Event Investigation Questionnaire," which was marked as confidential and not to be copied. The Questionnaire indicated a date of 4/7/11 related to an incident on 4/5/11. The form indicated, "Nature of Event: Res. Abuse: Allegation ?"</p> <p>The section of the form for "Interview with Resident" failed to indicate specifics of the resident's possible allegation of abuse, but documented the resident's family history related to abuse, alcoholism, and mental health issues, the resident's fear of being sent away, and his right to refuse care. The documentation also included instruction provided to the resident in regard to appropriate expression of anger and following policy.</p> <p>The folder also included a statement written and signed by LPN#3 indicating the following:</p>				<p>each investigation to ensure compliance with investigation and reporting procedures.</p> <p><b>By what date the systemic changes will be completed?</b> June 6, 2011</p>		

DEPARTMENT OF HEALTH AND HUMAN SERVICES  
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 06/09/2011

FORM APPROVED

OMB NO. 0938-0391

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	<p>on the morning of 4/5/11, LPN #3 attempted three times to administer the resident's medications, and the resident refused; medical records informed the nurse the resident's physician was enroute to the facility and needed the resident's vital signs taken before he arrived; the nurse put her left hand on the resident's bed rail to get the blood pressure, and the resident began yelling and cursing; the resident scratched the nurse's left hand with his right hand; the nurse tried to leave the room, the resident hit and kicked at the nurse multiple times; and the nurse only attempted to obtain vital signs on the resident's right arm. The folder also included documentation of inservice provided to LPN #3 on 4/7/11 related to "Abuse Prevention, Resident Rights, Approach [symbol for with] Resident, Ensure to approach calmly, provide personal space, attempt with different staff member. Reviewed behavior care plan."</p>						

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	<p>During interview with the Administrator on 5/13/11 at 2:45 p.m., the Administrator indicated the incident on 4/5/11 was not investigated as an allegation of abuse and reported to the Indiana State Department of Health, because the resident was not alleging assault. The Administrator indicated the concern about the nurse had come up during a conversation between her and the resident, and when she had asked the resident if the nurse had put her hands on him, he said no. The Administrator indicated the resident is manipulative and now is using the idea about the nurse putting her hands on him, since he wants the nurse fired. The Administrator indicated she did not interview anyone except the resident's former roommate about the incident on 4/5/11, and she did not write documentation related to the interview. The Administrator indicated the resident's behaviors and management of the resident's behaviors are discussed frequently</p>						

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	<p>at Interdisciplinary Team meetings. The Administrator indicated the resident reported the incident as assault to the state surveyors on 4/25/11 during the facility's recent recertification survey.</p> <p>During the same interview, Administrator indicated the allegation of abuse was reported to the Indiana State Department of Health when state surveyors reported the resident's allegation of assault to her on 4/25/11. The Administrator indicated her notes about the allegation of assault from the surveyors were the "chicken scratch" documentation in the file folder. The Administrator looked at the documentation and indicated the surveyors told her: the resident reported assault; the nurse took her right hand and slammed on the bed; the nurse took her fist, pinned his leg down, and tried to take his blood pressure on his left leg; and the nurse put her hands on him without permission, and gave no explanation of why she had to get</p>						

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	<p>the blood pressure. The Administrator indicated she may have made notes in the resident's record related to the allegation of assault reported by the surveyors.</p> <p>An Employee Communication Form in the file folder indicated LPN #3 was suspended 4/25/11 and returned to work 4/25/11. The form indicated, "Employer Statement: On 4/25/11 it was alleged that EE [meaning uncertain] assaulted resident per resident's claim," and "Summary of Discussion with Employee: Per Abuse Prohibition, Reporting &amp; Investigation, it is the facility policy to remove staff and remain suspended until investigation is completed. Upon investigation, resident story changed and EE story remain the same. No abuse was found. EE may return after reading resident rights and completion of test." The document was signed by LPN #3 and the DON on 4/25/11 and by the Administrator on 4/27/11.</p>						

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	<p>The Administrator indicated no further investigation into the allegation was made after surveyors reported to her that the nurse had assaulted the resident.</p> <p>Resident J's record was reviewed on 5/13/11 at 3:15 p.m. The record indicated the resident's diagnoses included, but were not limited to, vascular uncomplicated dementia, joint contracture, mood disorder, and hemiplegia.</p> <p>Interdisciplinary Progress Notes, dated 4/6/11 and signed by the Social Worker, indicated the resident was experiencing worsening behaviors, verbal and physical aggression toward the staff, and refusal of medications and blood sugar checks.</p> <p>Interdisciplinary Progress Notes, dated 4/26/11 at 5:00 p.m. and signed by the Administrator, indicated, "This writer spoke with Ombudsman [name of local Ombudsman] r/t [related to]</p>						

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F0282 SS=D	<p>meeting with resident. Resident alleged that nurse forced him to get vitals X 2 once in his right arm and then on his right leg/ankle which was different from his allegation from previous interviews. Resident has a history of making false accusations toward staff...." The documentation failed to indicate further investigation into the allegation of assault reported by the state surveyors on 4/25/11.</p> <p>3.1-28(a)</p> <p>The services provided or arranged by the facility must be provided by qualified persons in accordance with each resident's written plan of care.</p> <p>Based on record review and interview, the facility failed to ensure lab work was obtained as ordered by the physician for 1 of 8 residents reviewed related to lab work in a sample of 9. (Resident B)The facility also failed to ensure medications were administered as ordered by the physician for 2 of 8 residents reviewed related to</p>			F0282	<p>F 282 483.20(k)(ii) Services by Qualified Persons/Per Care Plan It is the practice of this provider to ensure that ordered laboratory orders are obtained and medications are administered as ordered by the physician.</p> <p><b>What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice:</b> The physician of resident B was notified of potassium on 4/6/2011 for clarification. New orders were received. The physician of resident B was notified of BMP on 3/9/2011, new orders were received. Labs were completed stat with</p>		05/27/2011

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	<p>medication administration in a sample of 9. (Residents B and I)</p> <p>Findings include:</p> <p>1. The clinical record for Resident B was reviewed on 5/11/11 at 12:45 p.m. The record indicated the resident was admitted to the facility on 1/21/11.</p> <p>A physician's order, dated 1/24/11, indicated, "D/C [discontinue] Dx [diagnosis] Dehydration Add Dx - hypokalemia [low potassium], hyponatremia [low sodium]...."</p> <p>Physician's admission orders, signed by the physician on 1/23/11, included, but were not limited to, Potassium 40 mEq [milliequivalents] PO [by mouth] TID [three times daily] (supplement)."</p> <p>Nurse's Notes for 3/4/11 at 6:15 p.m. indicated, "Labs reported to MD of potassium being @ critical level 6.9, orders received to hold</p>				<p>potassium levels within normal levels. Licensed nurses were in-serviced on 5/26/2011 regarding policy on labs to include completion as ordered by physician and post tests were completed..</p> <p>Resident I's physician was notified of medications on 4/26/2011 and 4/27/2011 with new orders received. The re-admitted nurse was educated regarding re-admitting procedures to ensure discharging medications have been ordered.</p> <p><b>How will you identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken:</b></p> <p>The facility recognizes that residents with lab orders and those residents admitted /re-admitted to the facility have the potential to be affected by this practice.</p> <p>A full facility audit was conducted All medical records identified were reviewed to ensure physician notification was completed. Resident admitted/re-admitted were reviewed to ensure discharge orders were transcribed as verified by attending physician.</p> <p>Licensed nurses were in-serviced on 5/26/2011 regarding policy on labs to include completion as ordered by physician and post tests were completed.</p> <p>Licensed nurses were in-serviced on 5/26/2011 regarding admission/re-admission policy to include verification and transcription of orders with post tests completed.</p> <p><b>What measures will be put into place or what systemic changes you will make to ensure that the deficient practice does not recur:</b></p> <p>Licensed nurses were educated on 5/26/2011 on the policy for laboratory orders, including completion as ordered with post tests completed. Treatment Administration Records were</p>		

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	<p>potassium, start IV [intravenous] NS [normal saline] bolus...."</p> <p>A. The Medication Administration Record (MAR) for March 2011 indicated the resident received no potassium supplements after 3/4/11 through 3/31/11.</p> <p>Documentation in the physician's orders section of the record lacked indication the physician order to resume potassium supplements.</p> <p>The MAR for April 2011 indicated the resident received potassium chloride, 40 mEq, by mouth three times daily on 4/1, 4/2, and 4/5/11. The MAR indicated the resident received the medication two times daily on 4/4 and 4/6/11.</p> <p>A physician's order, dated 4/5/11, indicated, "KCl [potassium chloride] 10 mEq, i [one] PO [by mouth] QD [every day]."</p> <p>Nurse's Notes for 4/6/11 at 9:55 a.m. indicated, "Call to ARNP</p>				<p>reviewed to ensure all lab orders present.</p> <p>The DNS/designee will log and track lab orders on Lab Tracking Log to include date of order, date lab notified, date drawn, date results received and date physician notified.</p> <p>Licensed nurses were also educated on 5/26/2011 regarding admission policy and procedure with post tests completed.</p> <p>The DNS/designee will complete admission audit first business day after admission to include review of discharging and admission orders for medications.</p> <p><b>How the corrective action(s) will be monitored to ensure the deficient practice will not recur:</b></p> <p>A CQI Audit of laboratory tool will be utilized weekly x 4 monthly x 2 then quarterly thereafter to monitor for compliance.</p> <p>DNS/designee will monitor audits, to ensure completion of audits.</p> <p>The DNS/designee will complete admission audit first business day after admission to include review of discharging and admission orders for medications.</p> <p>Data collected will be submitted to the CQI Committee for review and follow up as needed. An action plan will be developed as needed for issues identified by the CQI process.</p> <p>Compliance Date: 5/27/2011</p> <p>identifying all laboratory orders. <input type="checkbox"/></p>		

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	<p>[Advanced Registered Nurse Practitioner] to clarify KCl order...."</p> <p>A physician's order, dated 4/6/11, indicated, "D/C [discontinue] KCl 40 mEq TID [three times daily], Continue KCl 10 mEq PO daily as ordered on 4/5/11.</p> <p>B. Physician's orders, dated 3/4/11 at 6:30 p.m. indicated specific orders for the intravenous fluids. Physician orders, dated 3/4/11 at 9:30 p.m. indicated intravenous fluids should be discontinued due to infiltration, oral fluids pushed, and "Repeat BMP [basic metabolic profile] q [every] a.m. [morning] until stable. Hold potassium."</p> <p>Documentation in the lab report section of the record lacked indication of daily BMPs.</p> <p>During interview on 5/11/11 at 3:50 p.m., the Medical Records Director indicated she had contacted the lab, and no BMPs had been done on</p>						

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	<p>3/5, 3/6, 3/7, and 3/8/11.</p> <p>A physician's order, dated 3/9/11, indicated, "STAT [immediate] BMP." A lab report, dated 3/9/11, indicated labs were within normal limits for potassium at 4.8, with a reference range of 3.6 to 5.0.</p> <p>A physician's order, dated 4/6/11, indicated, "...CBC [complete blood count], CMP [complete metabolic profile] in AM [morning]." "Care Plan Update" on the physician's order form indicated, "Problem: Confusion" with "Goal: Identify possible reversible factors." Interventions included, but were not limited to, "Labs per order...."</p> <p>Documentation in the lab report section failed to indicate the results of the labs ordered for 4/7/11.</p> <p>During interview on 5/12/11 at 5:15 p.m. the facility's Nurse Consultant indicated the lab ordered on 4/7/11 was not done.</p>						

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	<p>2. The clinical record for Resident I was reviewed on 5/12/11 at 10:30 a.m. The record indicated the resident was admitted 3/22/11, returned to the hospital on 3/24/11, was readmitted on 3/26/11, returned to the hospital on 3/27/11, was readmitted on 4/7/11 and returned to the hospital on 4/9/11. The resident was readmitted on 4/21/11.</p> <p>The hospital Discharge Summary, dated 4/21/11, indicated diagnoses included, but were not limited to, chronic abdominal pain and diarrhea with a questionable gastrinoma. The "Hospital Course" section indicated, "...with history of chronic abdominal pain and diarrhea...admitted for worsening of her symptoms. The patient was re-seen by GI [gastrointestinal] and again there was highly [sic] concern for gastrinoma. The patient's octreotide [antidiarrheal medication] dosing was adjusted....The patient clinically started to improve gradually and cleared by GI to be discharged</p>						

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	<p>home...."</p> <p>Hospital discharge orders, signed by the physician on 4/21/11, included, but were not limited to continuation of the following medications, "Ocreotide 100 mcg [micrograms]/ml [milliliter] injectable, 50 micrograms subcutaneously, 3 times per day" and Granisetron [antiemetic medication] 1 mg [milligram]/ml injectable, 2 mg, intravenous, every morning." A small question mark was indicated next to the name of the Granisetron.</p> <p>Documentation failed to indicate the orders for the Ocreotide and Granisetron were transcribed onto the facility's physician's orders list at readmission. Documentation on the Medication Administration Record failed to indicate the medications were administered 4/21 through 4/26/11.</p> <p>Nurse's Notes for 4/26/11 at 11:00 p.m. indicated, "N/O [new order]"</p>						

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	<p>Octreotide 100 mcg/ml inj [inject] 50 mcg SubQ [subcutaneously] TID [three times daily]. Ordered STAT [immediately]...."</p> <p>Nurse's Notes for 4/27/11 at 1:30 p.m., indicated, "Reviewed H&amp;P [History and Physical] [symbol for with] MD. N/O for Granisetron."</p> <p>The Medication Administration Record (MAR) for 4/21/11 through 4/30/11 indicated an undated entry for "Granisetron 2 mg, i [one] PO [by mouth] QD [every day]. Give 1st dose when arrives fr [from] pharmacy." A nurse's initials on the MAR indicated the first dose was administered on 4/27/11.</p> <p>During interview on 5/12/11 at 4:45 p.m., the facility's Nurse Consultant indicated when Resident I was readmitted on 4/21/11, the Ocreotide was not placed on the re-write of physician's orders. She indicated the nurse had been educated and a medication error report had been written.</p>						

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F0309 SS=D	<p>During interview on 5/12/11 at 5:20 p.m., the Nurse Consultant provided copy of a Medication Error Acknowledgement indicating "Description of error: When completed admission failed to carry over &amp; verify Granistron and Ocreotide."</p> <p>This federal tag relates to Complaints IN00090287 and IN00090093.</p> <p>3.1-35(g)(2)</p> <p>Each resident must receive and the facility must provide the necessary care and services to attain or maintain the highest practicable physical, mental, and psychosocial well-being, in accordance with the comprehensive assessment and plan of care.</p> <p>Based on record review and interview, the facility failed to ensure management of the care of the resident with hyperkalemia [high blood potassium level] by obtaining ordered blood work for</p>			F0309	<p>F 309 483.25 Provide care/services for highest well being.</p> <p>It is the practice of this provider to ensure that residents receive services including labs to manage hyperkalemia.</p> <p><b>What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice:</b></p>		05/27/2011

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	<p>monitoring and following physician's orders for potassium supplements for 1 of 1 resident reviewed related to hypokalemia in a sample of 9. (Resident B)</p> <p>Findings include:</p> <p>The clinical record for Resident B was reviewed on 5/11/11 at 12:45 p.m. The record indicated the resident was admitted to the facility on 1/21/11.</p> <p>A physician's order, dated 1/24/11, indicated, "D/C [discontinue] Dx [diagnosis] Dehydration Add Dx - hypokalemia [low potassium], hyponatremia [low sodium]...."</p> <p>Physician's admission orders, signed by the physician on 1/23/11, included, but were not limited to, Potassium 40 mEq [milliequivalents] PO [by mouth] TID [three times daily] (supplement)."</p> <p>Nurse's Notes for 3/4/11 at 6:15</p>				<p>The physician was notified of the lab results of resident B on 4/5/11 for medication clarification and again on 4/6/11 with stat lab ordered. Lab was completed showing potassium level within normal limits.</p> <p><b>How will you identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken:</b> The facility recognizes that residents with laboratory orders have the potential to be affected by this practice. A full facility audit was conducted. All medical records identified were reviewed to ensure physician notification was completed. Licensed nurses were educated on 5/26/2011 on the policy for laboratory orders including completion as ordered with post tests completed.</p> <p><b>What measures will be put into place or what systemic changes you will make to ensure that the deficient practice does not recur</b> Licensed nurses were educated on 5/26/2011 on the policy for laboratory orders, including completion as ordered with post tests completed. Treatment Administration Records were reviewed to ensure all lab orders present.</p> <p>The DNS/designee will log and track lab orders on Lab Tracking Log to include date of order, date lab notified, date drawn, date results received and date physician notified. How the corrective action(s) will be monitored to ensure the deficient practice will not recur A CQI Audit of laboratory tool will be utilized weekly x 4 monthly x 2 then quarterly thereafter to monitor for compliance. DNS/designee will monitor audits, to ensure completion of audits. Data collected will be submitted to the CQI Committee for review and</p>		

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	<p>p.m. indicated, "Labs reported to MD of potassium being @ critical level 6.9, orders received to hold potassium, start IV [intravenous] NS [normal saline] bolus...."</p> <p>Physician's orders, dated 3/4/11 at 6:30 p.m. indicated specific orders for the intravenous fluids.</p> <p>Physician orders, dated 3/4/11 at 9:30 p.m. indicated intravenous fluids should be discontinued due to infiltration, oral fluids pushed, and "Repeat BMP [basic metabolic profile] q [every] a.m. [morning] until stable. Hold potassium."</p> <p>Documentation in the lab report section of the record lacked indication of daily BMPs.</p> <p>During interview on 5/11/11 at 3:50 p.m., the Medical Records Director indicated she had contacted the lab, and no BMPs had been done on 3/5, 3/6, 3/7, and 3/8/11.</p> <p>A physician's order, dated 3/9/11, indicated, "STAT [immediate]</p>				<p><b>follow up as needed. An action plan will be developed as needed for issues identified by the CQI process.</b></p> <p>Compliance Date: 5/27/2011</p> <p>::</p> <p>identifying all laboratory orders.</p>		

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	<p>BMP."</p> <p>The lab report, dated 3/9/11, indicated results were within normal limits for potassium at 4.8, with a reference range of 3.6 to 5.0.</p> <p>The Medication Administration Record (MAR) for March 2011 indicated the resident received no potassium supplements after 3/4/11 through 3/31/11.</p> <p>Documentation in the physician's orders section of the record lacked indication the physician order to resume potassium supplements.</p> <p>The MAR for April 2011 indicated the resident received potassium chloride, 40 mEq, by mouth three times daily on 4/1, 4/2, and 4/5/11. The MAR indicated the resident received the medication two times daily on 4/4 and 4/6/11.</p> <p>A physician's order, dated 4/5/11, indicated, "KCl [potassium chloride] 10 mEq, i [one] PO [by</p>						

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	<p>mouth] QD [every day]."</p> <p>A physician's order, dated 4/6/11, indicated, "D/C [discontinue] KCl 40 mEq TID [three times daily], Continue KCl 10 mEq PO daily as ordered on 4/5/11, CBC [complete blood count], CMP [complete metabolic profile] in AM [morning]." Care Plan Update on the physician's order form indicated, "Problem: Confusion" with "Goal: Identify possible reversible factors." Interventions included, but were not limited to, "Labs per order...."</p> <p>Nurse's Notes for 4/6/11 at 9:55 a.m. indicated, "Call to ARNP [Advanced Registered Nurse Practitioner] to clarify KCl order and request labs."</p> <p>Documentation in the lab report section failed to indicate the results of the CBC and CMP ordered for 4/7/11.</p> <p>During interview on 5/12/11 at 5:15</p>						

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F0333 SS=D	<p>p.m. the facility's Nurse Consultant indicated the lab ordered on 4/7/11 was not done.</p> <p>This federal tag relates to Complaints IN00090093 and IN00090287.</p> <p>3.1-37(a)</p> <p>The facility must ensure that residents are free of any significant medication errors. Based on record review and interview, the facility failed to ensure medications were administered as prescribed by the physician upon discharge from the hospital and during an episode of elevated blood potassium. The deficient practice resulted in a significant medication error for 2 of 8 residents reviewed related to medication administration in a sample of 9. (Resident I and Resident B)</p> <p>Findings include:</p> <p>1. The clinical record for Resident</p>			F0333	<p>F 333 RESIDENTS FREE OF SIGNIFICANT MED ERRORS It is the practice of this facility to administer medications as ordered. <b>What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice:</b></p> <p>. The physician for resident I was notified on 4/26/11 and new orders were received. The admitted nurse had received education regarding transcription of admission orders on 4/27/2011. The physician was notified of the lab results of resident B on 4/5/11 for medication clarification and again on 4/6/11 with stat lab ordered. Lab was completed showing potassium level within normal limits. <b>How will you identify other</b></p>		05/27/2011

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	<p>I was reviewed on 5/12/11 at 10:30 a.m. The record indicated the resident was admitted 3/22/11, returned to the hospital on 3/24/11, was readmitted on 3/26/11, returned to the hospital on 3/27/11, was readmitted on 4/7/11 and returned to the hospital on 4/9/11. The resident was readmitted on 4/21/11.</p> <p>The hospital Discharge Summary, dated 4/21/11, indicated diagnoses included, but were not limited to, chronic abdominal pain and diarrhea with a questionable gastrinoma. The "Hospital Course" section indicated, "...with history of chronic abdominal pain and diarrhea...admitted for worsening of her symptoms. The patient was re-seen by GI [gastrointestinal] and again there was highly [sic] concern for gastrinoma. The patient's octreotide [antidiarrheal medication] dosing was adjusted....The patient clinically started to improve gradually and cleared by GI to be discharged home...."</p>				<p><b>residents having the potential to be affected by the same deficient practice and what corrective action will be taken:</b> The facility recognizes that all residents have the potential to be affected by this practice. Medication Administration Records were reviewed for appropriate documentation. All admissions/readmissions in last 30 days were audited to ensure transcription of verified discharging orders.</p> <p><b>What measures will be put into place or what systemic changes you will make to ensure that the deficient practice does not recur</b> The DNS/designee will audit all new orders and ensure transcribed onto medication administration record appropriately, Monday thru Friday excluding holidays. All new admissions/re-admissions will be audited on first business day following admission to ensure transcription accurate as compared to verified discharge orders. All re-writes will be verified as accurate by two licensed nurses prior to beginning of month. Licensed nurses received education on 5/26/11 regarding order transcription, admission process and re-write procedures with post tests completed.</p> <p><input type="checkbox"/></p> <p><b>How the corrective action(s)</b></p>		

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	<p>Hospital discharge orders, signed by the physician on 4/21/11, included, but were not limited to continuation of the following medications, "Ocreotide 100 mcg [micrograms]/ml [milliliter] injectable, 50 micrograms subcutaneously, 3 times per day" and Granisetron [antiemetic medication] 1 mg [milligram]/ml injectable, 2 mg, intravenous, every morning." A small question mark was indicated next to the name of the Granisetron.</p> <p>Documentation failed to indicate the orders for the Ocreotide and Granisetron were transcribed onto the facility's physician's orders list at readmission. Documentation on the Medication Administration Record failed to indicate the medication was administered 4/21 through 4/26/11.</p> <p>Nurse's Notes for 4/26/11 at 11:00 p.m. indicated, "N/O [new order] Octreotide 100 mcg/ml inj [inject]</p>				<p><b>will be monitored to ensure the deficient practice will not recur</b>  <b>The DNS/designee will complete CQI audit tool of MAR's, weekly x 4 monthly x 2 then quarterly thereafter to monitor for compliance to ensure new orders have been transcribed correctly</b>  <b>The DNS/designee will conduct post-admission audit first business day after admission for accuracy of verified orders.</b>  <b>The IDT will complete a review of admission records 3 days post admission.</b>  <b>The Data collected will be submitted to the CQI Committee for review and follow up as needed. An action plan will be developed as needed for issues identified by the CQI process.</b>  <input type="checkbox"/>  <b>Date of Compliance: 05/27/2011</b>          ::       </p>		

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	<p>50 mcg SubQ [subcutaneously] TID [three times daily]. Ordered STAT [immediately]...."</p> <p>The Medication Administration Record (MAR) for 4/21/11 through 4/30/11 indicated an undated entry for "Granisetron 2 mg, i [one] PO [by mouth] QD [every day]. Give 1st dose when arrives fr [from] pharmacy." A nurse's initials on the MAR indicated the first dose was administered on 4/27/11.</p> <p>During interview on 5/12/11 at 4:45 p.m., the facility's Nurse Consultant indicated when Resident I was readmitted on 4/21/11, the Ocreotide was not placed on the re-write of physician's orders. She indicated the nurse had been educated and a medication error report had been written.</p> <p>During interview on 5/12/11 at 5:20 p.m., the Nurse Consultant provided copy of a Medication Error Acknowledgement indicating "Description of error: When</p>						

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	<p>completed admission failed to carry over &amp; verify Granisetron and Ocreotide."</p> <p>2. The clinical record for Resident B was reviewed on 5/11/11 at 12:45 p.m. The record indicated the resident was admitted to the facility on 1/21/11.</p> <p>A physician's order, dated 1/24/11, indicated, "D/C [discontinue] Dx [diagnosis] Dehydration Add Dx - hypokalemia [low potassium], hyponatremia [low sodium]...."</p> <p>Physician's admission orders, signed by the physician on 1/23/11, included, but were not limited to, Potassium 40 mEq [milliequivalents] PO [by mouth] TID [three times daily] (supplement)."</p> <p>Nurse's Notes for 3/4/11 at 6:15 p.m. indicated, "Labs reported to MD of potassium being @ critical level 6.9, orders received to hold potassium, start IV [intravenous]</p>						

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	<p>NS [normal saline] bolus...."</p> <p>Documentation in the physician's orders section of the record lacked indication the physician order to resume potassium supplements.</p> <p>The Medication Administration Record (MAR) for March 2011 indicated the resident received no potassium supplements after 3/4/11 through 3/31/11.</p> <p>The MAR for April 2011 indicated the resident received potassium chloride, 40 mEq, by mouth three times daily on 4/1, 4/2, and 4/5/11. The MAR indicated the resident received the medication two times daily on 4/4 and 4/6/11.</p> <p>A physician's order, dated 4/5/11, indicated, "KCl [potassium chloride] 10 mEq, i [one] PO [by mouth] QD [every day]."</p> <p>Nurse's Notes for 4/6/11 at 9:55 a.m. indicated, "Call to ARNP [Advanced Registered Nurse</p>						

DEPARTMENT OF HEALTH AND HUMAN SERVICES  
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 06/09/2011

FORM APPROVED

OMB NO. 0938-0391

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	Practitioner] to clarify KCl order...."  A physician's order, dated 4/6/11, indicated, "D/C [discontinue] KCl 40 mEq TID [three times daily], Continue KCl 10 mEq PO daily as ordered on 4/5/11.  This federal tag relates to Complaints IN00090287 and IN00090093.  3.1-25(b)(9) 3.1-48(c)(2)						

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F0441 SS=F	<p>The facility must establish and maintain an Infection Control Program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of disease and infection.</p> <p>(a) Infection Control Program The facility must establish an Infection Control Program under which it - (1) Investigates, controls, and prevents infections in the facility; (2) Decides what procedures, such as isolation, should be applied to an individual resident; and (3) Maintains a record of incidents and corrective actions related to infections.</p> <p>(b) Preventing Spread of Infection (1) When the Infection Control Program determines that a resident needs isolation to prevent the spread of infection, the facility must isolate the resident. (2) The facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease. (3) The facility must require staff to wash their hands after each direct resident contact for which hand washing is indicated by accepted professional practice.</p> <p>(c) Linens Personnel must handle, store, process and transport linens so as to prevent the spread of infection.</p> <p>Based on observation, record review, and interview, the facility failed to identify and investigate for a possible scabies outbreak when a</p>			F0441	<p>This provider respectfully requests additional evidentiary information be entered into the 2567L and a lowering of scope and severity/ denial for resident C, D, F, and G. The current</p>		05/27/2011

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	<p>resident was diagnosed with possible scabies and treated with a scabicial medication. The resident had ongoing signs and symptoms of scabies. The facility failed to assess residents and staff related to rashes and itching and failed to identify exposure contacts for treatment of residents and staff exposed to the resident, in accordance with its infection control policy for Scabies Control. The deficient practice affected 1 of 1 resident reviewed who was treated for the diagnosis of "possible scabies." (Resident D) 5 of 8 residents reviewed in the sample of 9 had rashes and itching which were not identified as possible scabies as indicated in the facility's policy. (Residents C, D, E, F, and G) The deficient practice had the potential to affect all residents at the facility.</p> <p>Findings include:</p> <p>1. During observation of personal care on 5/11/11 at 1:25 p.m., CNAs</p>				<p>2567L information omits significant facility information and therefore misrepresents the care and assessment administered by the provider.</p> <p>Resident D had multiple consultation visits from various physicians including dermatologist for treatment of complaint of itching and rash since 11-30-2010.</p> <p>Per surveyor comment on page 30 of 43 " the facility failed to identify and investigate for a possible scabies outbreak when a resident was diagnosed with possible scabies and treated with a scabicial mediation."</p> <p><b>This implies that the facility had not assessed the resident related to rashes and itching and that there was a resident with a positive diagnosis of scabies. Resident D was being treated for questionable allergy versus fungal rash since 11-30-2010 and has not ever had a positive diagnosis of scabies. The facility contends that the resident did not have a positive diagnosis of scabies and was being treated for rash and itching as identified by facility. Most recent scraping test results shows no scabies; therefore, no possible outbreak could occur.</b></p> <p><b>It is the policy of this facility to eliminate and treat irritated skin areas, specifically a skin irritation caused by the itch</b></p>		

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	<p>#2 and #4 were outside Resident D's door and donned gown, mask and gloves in preparation for transferring Resident D from wheel chair to bed to provide personal care. A sign next at the door indicated to stop and see the nurse before entering. During interview at this time, CNA #4 indicated she was unsure why the protective equipment was used, but the nurse would know. CNA #4 indicated the family did not use the protective equipment when visiting the resident. During care, Resident D was observed to have a scaly, red raised rash on the chest and abdomen area. The inner thighs were observed to have discreet red dots the size of large pin heads. The resident was observed to scratch in a digging motion at the chest and abdomen during care. CNA #2 indicated the machine on the end of the bed was for Resident D's wound vac for the wound on his back, but she thought the wound vac was discontinued at the resident's medical appointment</p>				<p>mite, <b>Sarcoptes Scabiei</b>, and to prevent the spread of infection. The policy was followed as evidenced based by which a concern was brought to the attention to the ED of a staff member that admitted to having scabies. Once the concern was identified, the ED immediately responded prior to the time of survey, which negates the surveyor comment that the facility failed to identify and investigate for a possible scabies outbreak. The facility immediately implemented a plan of action and followed the policy and procedure of Scabies Control. All residents skin assessments were completed. All staff were inserviced and inspected for any areas of concern. Any areas of concern identified on residents were further assessed. Any staff member who had areas of concern were also sent for further assessment. The facility correctly did identify resident G to have a rash and itching and took appropriate measures to treat. Appropriate interventions were put in place to help resident G with rash and skin irritation. Facility needs to clarify diagnosis of scabies for resident G, in which there was no positive diagnosis of</p>		

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	<p>earlier in the day.</p> <p>During observation on 5/11/11 at 3:15 p.m., Resident D was observed seated in his high back wheel chair in the hallway at the nurse's station. The resident was wearing a short sleeved shirt and geri-sleeves on both arms. The resident's head was drooping forward. The fingers of the resident's two hands were interlaced, writhing in a back and forth motion. The resident used his left hand to scratch at the right upper arm and forearm and his right hand to scratch at the left upper arm and forearm. The resident reached inside his shirt with his left hand and scratched the chest and shoulder vigorously.</p> <p>During observation on 5/11/11 at 3:35 p.m., Resident D was seated in his high back wheel chair at the nurse's station. The resident was observed with his right hand beneath his shirt scratching with a digging motion on the chest and down the arm. The left hand was</p>				<p><b>scabies. Order obtained for lab scraping, and waiting on results. It was explained to ED that the Medical Director's nurse practioner, assessed resident G and based on clinical observations did show signs of scabies. To prevent the spread of infection due to possible exposure to scabies, facility implemented cleaning and treatment plan. The facility contends that resident D's clinical condition did not have the potential to affect other residents and respectfully requests a decrease in scope and severity of the citation. The facility did in fact investigate, control and prevent widespread infection when a true concern was identified. No residents in the facility had or have scabies during January thru the present date. However, in response to the alleged deficient practice the following corrective action has been implemented.</b></p> <p><b>For Prevention of possible exposure from staff member, immediate action did take place:</b></p> <p><b>C.N.A was suspended until further investigation could be completed. It is the practice of this facility to prohibit employees with a communicable disease or</b></p>		

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	<p>observed at the right elbow scratching and scratching.</p> <p>During observation on 5/11/11 at 4:15 p.m., Resident D was again observed seated in his high back wheel chair in the hallway at the nurse's station. The resident's gerisleaves were down around his wrists, and the resident was scratching vigorously at his hands.</p> <p>The clinical record for Resident D was reviewed on 5/11/11 at 11:40 a.m. The record indicated the resident was readmitted on 3/10/11 after hospitalization on 3/6/11 for treatment to a boil on the back.</p> <p>A visit note from a dermatologist's appointment, dated 1/26/11, indicated, "Excoriative dermatitis diffuse esp [especially] trunk. On Atarax....Call 10 days if not okay."</p> <p>A physician's order, dated 1/26/11, indicated, "Betamethasone Dipropionate [anti-inflammatory medication] 0.05% cream. Apply</p>				<p><b>infected skin lesions from direct contact with residents. Thoroughly inspect all individuals including staff and residents who have had possible contact</b></p> <p><b>All individuals with suspicion of possible exposure were treated at the same time. (Including all residents and staff, and offered to all visitors as well)</b></p> <p><b>A Schedule for the following was established:</b></p> <p><b>who would be treated and who will do the treating.</b></p> <p><b>Specific treatment instructions</b></p> <p><b>When and Where treatment will be done.</b></p> <p><b>A cleaning schedule for the entire facility including resident rooms, offices, therapy gym, dining rooms, shower rooms and all other areas was developed and completed.</b></p> <p><b>Linens and laundry were washed and bagged appropriately.</b></p> <p><b>Families and those at risk for possible exposure for scabies were notified.</b></p> <p><b>Staff has been educated on Infection Control policy and procedures including Scabies Control.</b></p> <p><b>C.N.A was later terminated due to unsafe practices that may cause injury or illness aeb not following proper infection control policy and procedures.</b></p>		

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	<p>topically to rash on neck, torso, bilateral arms &amp; back BID [twice daily]. D/C [discontinue] Mycolog [antifungal medication] ointment."</p> <p>Nurse's Notes indicated the following related to skin issues after 1/26/11:</p> <p>2/1/11 at 3:45 p.m., "...Rash continues, less scratching today....</p> <p>2/2/11 at 2:00 p.m., "N.O. [new order] per [name of attending physician], apply warm compresses to L [left] ear TID [three times daily], cleanse area to L ear [symbol for with] NS [normal saline] apt dry apply Bactroban [antibiotic ointment] QD [every day] &amp; PRN [as needed]."</p> <p>2/8/11 at 2:00 p.m., "N.O. [new order] per [name of attending physician], apply warm compresses to boil on L axilla Q [every] shift...."</p> <p>A visit note from an appointment</p>						

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	<p>with an allergy/asthma specialist, dated 2/9/11, indicated, "Chief Complaint: Rash on back and all over. Keeps getting boils. History of Present Illness: [some words illegible]...started on belly &amp; waist up only scratchy and itchy, no abx [antibiotics] no [symbol for change] in meds [medications] saw [name of dermatologist] took Prednisone [anti-inflammatory medication] X 1 week then again + has MRSA [methicillin resistant staphylococcus aureus] - Bactroban cream." The Review of Symptoms section of the note indicated, "Skin/Breast: Skin rash, severe itching." The "Examination Detail" section of the note indicated for Skin: "Excoriated areas - neck, chest, arms." The "Diagnosis" section of the record indicated, "Poss. [possible] scabies. MRSA." The note indicated the resident should return in three weeks for follow-up.</p> <p>A physician's order was received for "Doxycycline [antibiotic] 100</p>						

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	<p>mg, take i [one] PO [by mouth] BID [twice daily] X 10 days. Elimate [scabicial medication] Cream. Apply topically all over body leave on for 8 hrs. then bath/shower Q day. D/C Betamethasone Dipropionate 0.05 Cream."</p> <p>The Treatment Administration Record indicated the Elimate cream was applied 2/9/11 on the night shift and the resident showered the next day.</p> <p>On 2/11/11 at 6:30 p.m., Nurse's Notes indicated the resident's order for Atarax (medication for itching) was increased from 25 mg three times a day to 50 mg three times daily, the Doxycycline was discontinued, and an order was received for "Prednisone [anti-inflammatory] 20 mg, take ii [two] PO BID X 1 day then Prednisone 20 mg BID PO X 7 days."</p> <p>The next Nurse's Note was dated 3/1/11 and indicated, "...Remains</p>						

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	<p>rashy...." Nurse's Notes for 3/3 through 3/6/11 indicated the resident experienced a change in condition, including development of a draining boil on the back and was transferred to the hospital on 3/6/11.</p> <p>The hospital History and Physician indicated, "...He was transferred to the Emergency Room secondary to an unexplained rash and a large cellulitis/abscess area on his back....The daughter states that the rash has been present since November and he has been treated with [sic] scabies in the past." The Plan indicated, "...I will consult Dermatology regarding the patient's rash as I am unsure as to what it is...." The hospital Dermatology consult indicated, "...Doubt scabies."</p> <p>On 5/11/11 at 2:50 p.m., the Administrator provided a copy of the facility's Scabies Control Policy, dated July 2008. The policy indicated, "POLICY: It is the</p>						

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	<p>policy of this facility to eliminate and treat irritated skin areas, specifically a skin irritation caused by the itch mite, <i>Sarcoptes scabiei</i>, and to prevent the spread of infection. STANDARD: The following are common signs, symptoms, transmission route and diagnosis: - Intense itching and eruptions of burrows (small discolored lines) and small red elevations of the skin, which may have fluid in them. - The hands, fingers, wrist, underarms, genitalia and inner aspect of the thigh are the most common areas infected....- Transmitted by physical contact. PROCEDURE: - Thoroughly inspect all individuals (residents and staff) who have had 'hands on' contact with the resident who has been diagnosed. - All individuals affected must be treated at the same time. - Notify the Director of Nursing, Housekeeping, Laundry, and Dietary Departments and in the Infection Control Practitioner. - Determine a schedule that includes the following: a. Who will be</p>						

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	<p>treated and who will do the treating.</p> <p>b. Specific treatment instructions.</p> <p>c. Where treatment will be done. d.</p> <p>When treatment will be done. e.</p> <p>When will the person be considered non-infected. - Write a second schedule for the following: f.</p> <p>Persons needing a second treatment one week later, or as prescribed by the attending physician. g. Persons with crusted or infected lesions needing routine monitoring...."</p> <p>During interview on 5/11/11 at 2:50 p.m., the Administrator, Director of Nursing (DON), and Nurse Consultant indicated they had a concern related to scabies in the facility. The Administrator indicated she worked Sunday, 5/7/11, and received report from a CNA that another CNA was not following standard precautions and had indicated she had been diagnosed with scabies. The Administrator indicated the CNA with scabies had been suspended and a plan was being implemented to treat all residents and staff for</p>						

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	<p>scabies and implement a thorough cleaning of the entire building. The Administrator indicated Resident G had been diagnosed with scabies today, based on his clinical assessment. The DON indicated scabies would be logged into the infection control records.</p> <p>During interview on 5/12/11 at 3:25 p.m., the Nurse Consultant indicated Resident D's attending physician had visited earlier in the day and decided the resident should go to the hospital to find out what the skin problem is and solve it for the resident.</p> <p>During interview on 5/13/11 at 3:40 p.m., the DON indicated Resident D was sent to the outpatient lab at the hospital for a skin scraping to determine if he had scabies. She indicated the hospital lab had to send the specimen to another lab and the results of the test would not be available for 48 to 72 hours.</p> <p>During interview on 5/13/11 at 3:50</p>						

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	<p>p.m. related to follow-up through the infection control program for the treatment Resident D had with the scabicial medication, Elimite, the DON indicated she would need to check the infection control logs. At 3:55 p.m., the DON indicated the diagnosis/treatment had not been noted on the log.</p> <p>2. The clinical record for Resident E was reviewed 5/11/11 at 10:45 a.m.</p> <p>Documentation in physician's orders indicated treatment for a rash to the abdomen and bilateral arms began 12/27/11 when a physician's order was received for "Hydrocortisone 1% cream to abd [abdomen] &amp; (B) [bilateral] arms R/T [related to] rash BID [two times daily]."</p> <p>A physician's order, dated 1/26/11, indicated, "Lachydrin 12% lotion, apply topically to torso, bilateral arms, and back - apply BID."</p>						

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	<p>A physician's order, dated 2/27/11, indicated, "Benadryl 25 mg P.O. [by mouth] q [every] 6 [symbol for hours] PRN [as needed]." The Care Plan Update on the physician's order form indicated, "Problem: Itching."</p> <p>A physician's order, dated 3/17/11, indicated, "N.O. rec'd [received] by [name of physician]. Start Hydrocortisone cream 1%. Apply cream to abd and bilateral arms q [every] shift and as needed r/t [related to] rash X 2 weeks. D/C [discontinue] current Hydrocort 1% cream." The Care Plan Update on the physician's order form indicated, "Problem: Rush, Pt [patient] to maintain skin integrity."</p> <p>A physician's order, dated 3/24/11, indicated, "Derm [dermatologist] to see" followed by the word "Rash" with a circle around it.</p> <p>Nurse's Notes indicated the resident was transported to a medical appointment on 4/5/11, and upon</p>						

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	<p>return, a physician's order, dated 4/5/11, indicated, "1. Start Cephalexin [antibiotic] 250 mg. Give 250 mg PO QID [four times daily] r/t rash. 2. Start Trimcinolone [anti-inflammatory] 0.1% cream 80 gram. Apply to bilateral arms, back and chest TID R/T rash. 3. Start Atarax 10 mg. Give 10 mg PO QID as needed R/T itching. D/C [discontinue] current Benadryl [allergy/itching medication] order." 4. Dove Soap - Pt [patient] to use only dove soap, hypoallergenic laundry detergent. 5. Apply Lubriderm lotion to dry skin [symbol for with] fragrance free and lanolin free."</p> <p>Nurse's Notes indicated the resident was transported to a medical appointment on 4/19/11, and upon return, a physician's order, dated 4/19/11, indicated, "Start Prednisone 10 mg R/T rash - Give 3 tabs P.O. Q a.m. [morning] [symbol for with] bkft [breakfast]." The Care Plan Update of the order form indicated, "Alter [sic] skin</p>						

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	<p>integrity."</p> <p>Nurse's Notes from 3/18/11 through 4/5/11 indicated Benadryl was administered for complaints of itching on the following dates and times: the following related to the resident's rash and itching: 3/21/11 at 10:48 p.m., 3/22/11 at 11:00 a.m., 3/23/11 at 10:00 a.m., 3/24/11 at 9:30 a.m., 3/26/11 at 3:00 a.m., 3/26/11 at 10:30 a.m., 3/27/11 at 11:00 a.m., 3/29/11 at 7:00 p.m., 3/31/11 at 12:30 p.m., 4/1/11 at 5:00 a.m., 4/1/11 at 10:45 a.m.</p> <p>Nurse's Notes for 4/2/11 at 11:00 p.m. indicated, "...Only notice res itching before lunch...."</p> <p>Nurse's Notes for 4/4/11 at 4:00 a.m. indicated, "...C/O itching [symbol for with] red bumps dry &amp; flaky skin."</p> <p>Nurse's Notes indicated Atarax was administered for itching as follows: 4/5/11 (no time indicated), 4/6/11 at 4:00 a.m., 4/7/11 at 5:30 a.m.,</p>						

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	<p>4/9/11 at 10:15 a.m., 4/13/11 at 3:00 a.m., 4/15/11 at 3:00 a.m., 4/24/11 at 10:00 a.m., 4/27/11 at 4:00 a.m., 5/1/11 at 11:00 p.m., and 5/7/11 at 9:50 a.m.</p> <p>Nurse's Notes also indicated the resident complained of itching as follows: 4/13/11 at 6:45 p.m., 4/14/11 at 2:00 a.m., 4/15/11 at 8:30 p.m., 4/18/11 at 8:00 p.m., 4/19/11 at 8:00 p.m., 4/23/11 at 8:30 p.m.</p> <p>Nurse's Notes for 4/16/11 at 3:00 a.m. indicated, "...con't [continued] to scratch [symbol for after] med [mediation] &amp; lotion...."</p> <p>Nurse's Notes for 4/17/11 at 4:15 a.m. indicated, "itchy rash to trunk &amp; BUE [bilateral upper extremities].</p> <p>Nurse's Notes for 5/1/11 at 11:00 p.m. indicated, "...was itching earlier in shift...."</p> <p>The Weekly Skin Assessment, dated</p>						

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	<p>5/4/11, indicated the resident had "Rashes." Notes indicated, "Note rash bilateral arms &amp; torso. Skin warm to touch and intact. Tx [treatment] complete q [every] shift. Tol. [tolerated] well. [symbol for no] S/S [signs and symptoms] of distress."</p> <p>On 5/8/11 at 7:00 p.m., Nurse's Notes indicated a physician's orders were received to "culture boil on back." On 5/9/11 at 1:30 p.m., the resident was transferred to the emergency room for evaluation and treatment of the wound.</p> <p>3. The clinical record for Resident F was reviewed on 5/11/11. at 11:25 a.m.</p> <p>Nurse's Notes, dated 4/28/11 at 2:00 p.m., indicated, "Res. [resident] C/O [complained of] generalized itching. MD notified. N.O. [new order] Claritin [allergy/itching medication] 10 mg PO Q day X 10 days...."</p>						

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	<p>Nurse's Notes, dated 5/5/11 at 2:40 p.m., indicated, "Res. has red rash to whole torso. MD notified. N.O. Triamcinolone 0.1% to rash BID X 10 days...."</p> <p>The physician's order for the Triamcinolone included the notation, "...Please send large amount r/t [related to large amount of rash.]"</p> <p>The Weekly Skin Assessment, dated 5/7/11, indicated, "...rash on abdomen."</p> <p>During observation of Resident F's personal care by CNA #4 and CNA #6 on 11:50 a.m., with two family members present, the resident was observed to have light red lines across the chest between the breasts. The resident was observed to scratch/dig at the upper arms and chest and complaint of itching. During interview with the resident's family member at this time, the family member indicated the resident had been treated with a</p>						

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		(X5) COMPLETION DATE	
	<p>lotion for scabies the preceding day, and she wanted to be sure the treatment would be repeated in seven days.</p> <p>During confidential telephone interview on 5/11/11 with the resident's family member, the family member indicated the resident complained about two weeks ago of itching. The family member indicated another family member said it looked like the resident had scabies. The family member said the doctor ordered Claritin and a lotion, but the resident continued to complain of itching.</p> <p>4. The clinical record for Resident C was reviewed on 5/12/11 at 11:00 a.m.</p> <p>A physician's order, dated 4/15/11, included, but was not limited to, "Benadryl cream to rash bid." The Care Plan Update section of the order form indicated a Problem of "Rash UE [upper extremities, abd</p>						

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	<p>[abdomen]/back." Documentation in Nurse's Notes and Weekly Skin Assessment Sheets failed to indicate a description of the resident's rash.</p> <p>The Medication Administration Record for April 15 through 25, 2011 indicated the Benadryl cream was applied two times daily. The Benadryl was withheld one time on 4/26/11 with the notation, "Benadryl withheld. rash subsided. Will notify MD." The Benadryl was applied one time on 4/28, 4/29 and 4/30/11. The Medication Administration Record for May 2011 indicated the medication was administered twice daily on May 1 through 7, once on May 8, twice on 5/9, and once on 5/10, 11, and 12/11.</p> <p>Documentation on the Weekly Skin Assessment, dated 5/3/11, failed to indicate the resident's rash.</p> <p>Nurse's Notes for 5/7/11 at 5:00 p.m., indicated, "Tx [treatment]</p>						

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	<p>applied to rash."</p> <p>5. The clinical record for Resident G was reviewed on 5/12/11 at 3:15 p.m.</p> <p>Nurse's Notes for 2/15 through 5/3/11 did not indicate information related to rashes and itching.</p> <p>A Weekly Skin Assessment, dated 5/11/11, indicated the resident had "Discoloration/Rash." The entry for "Description/Site" indicated, "Red raised areas." The site was not indicated.</p> <p>A Nurse Practitioner's note, dated 5/11/11 indicated: "Chief Complaint: Pt [patient] seen today for [illegible word] rash to groin &amp; abdomen. Pt. states pruritic [itching]." The note included, but was not limited to, "Location: abd [abdominal] rash linear; Severity: 3 excoriated areas; Duration: &gt; [greater than] 3 days per pt; Timing: Constant." The Review of Systems indicated, "Skin: Rash to</p>						

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	groin & abd." Exam indicated, "Gen [general]: Pruritis to abd; Abd: rash linear & [illegible word]; Skin: pruritic rash constant [symbol for with] dermatitis poss. [possible] scabies exposure." Assessment indicated, "1) Contact dermatitis 2) Pruritis 3) Anxiety." The Treatment Plan indicated the resident would be treated with a scabicial medication, all other medications would be continued, and follow-up as needed.  This federal tag relates to Complaint IN00090093.  3.1-18(b)(1)(A) 3.1-18(b)(2) 3.1-18(b)(3)						